

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008899	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHWEST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00093509</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 6/30/11</p> <p>Facility Number: 008899</p> <p>Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor</p> <p>Triumph Hospital Northwest Indiana, is in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.15-1, Dietetic services, Indiana Hospital Licensure Rules.</p> <p>QA: claughlin 08/04/11</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1